



Des Moines IA Health Link Public Comment Meeting

Wednesday, December 7, 2016

Time: 3 p.m. – 5 p.m.

Des Moines Central Library

Meeting Room

1000 Grand Ave., Des Moines, IA 50309

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Matt Highland - present	Amerigroup Iowa, Inc. - present	Dennis Tibben - present
Lindsay Paulson - present	AmeriHealth Caritas Iowa, Inc. - present	David Hudson - present
Sean Bagniewski - present	UnitedHealthcare Plan of the River Valley, Inc. - present	Jim Cushing – present
Allie Timmerman - present		Anthony Carroll - present
Korey Buchanan - present		Natalie Ginty - present
Adrian Olivares - present		

Comments:

Communications, Comments and Suggestions

A member raised concern about the lack of communication and advertisement for the meeting stating that they had not been notified of the meeting until the day prior and notice of the meeting was not posted on the main DHS or MCO webpages. The meeting was held at an inconvenient time for members and some members may not have been able to find transportation to the meeting due to the short notice. In regards to grievances, a member experienced issues with their MCO not clearly explaining their rights under the grievance process and after involving the Ombudsman's Office, was able to receive assistance with the filing of a grievance against their MCO. The member had also been told that there were no time limits for responses from the MCOs and the Ombudsman's Office had limited enforcement authority although issuing subpoenas on every MCO inquiry would be unrealistic. It has taken members extensive time to get issues sorted out due to misinformation and communication. A member advocate indicated that new members were receiving multiple, confusing packets of information in the mail and were not able to identify what information was importation and what was simply MCO promotional materials; members were accidentally throwing out necessary paperwork. Many of the documents sent to members are not available in the member's native language so members who speak English as a secondary language were throwing away important information and were having to ask friends for assistance with the materials. Limited English proficiency members were also having trouble filing complaints because the process was confusing and not easily accessible. There are issues with limited English proficiency members trying to utilize the MCO call center language lines and the MCO not offering the dialect or the specific language the member required; they struggle to communicate and members receive little assistance.

Comments from the State and MCOs today are the same comments as 7 months ago where providers are told to call their account representatives, the MCO would look into their issue,

and so forth. Account Managers are consistently changing and are not getting back to providers so the providers have little confidence in the State and MCO responses.

Value-Added Services

Healthy Behavior incentives and other MCO-specific value-added benefits were not being administered as originally stated, and the MCOs were not clearly conveying how the programs worked or qualifications for the services. As the value-added services were beyond the required Medicaid services, there was not oversight over the benefits beyond the MCOs.

Services and Coverage

A member had experienced issues with a service initially being authorized by their MCO and after starting treatment the MCO retrospectively denied the authorization stating that it was not a covered benefit; the benefit was listed as authorized on the MCO's website. The member was also told following the denial that they were not a member of their MCO's patient panel and when trying to contact the MCO for resolution, the member had to place multiple calls to multiple contacts receiving different answers depending on the representative. A member advocate stated that access to children's care has been a significant issue and that families were now required to see a doctor that was in the member's MCO provider network as opposed to seeing any Medicaid provider. Children who received speech or occupational therapy services were no longer able to access the services through the health care system and were seeking the services through the child's school. Title V used to cover care coordination and the MCOs were no longer doing so due to the removal of funding following implementation. It was also stated that unless a child was receiving waiver services and assigned a CM, there was not an established system for identifying high risk families to address their barriers in accessing health care. Some families were also not able to access services as the child's needs fell outside of what was defined as medical necessity. The unique needs of children were not being considered or addressed under the new program. A provider recently hosted a flu clinic and members had shown up because the MCOs had told them it was a free, covered, benefit although all members were later billed for the flu vaccine and told it was not a covered benefit. A member's parent stated that following the transition, some services had been discontinued due to redeterminations of medical necessity members were receiving services that they didn't need. All members were afraid to complain because many had already lost services in the transition to managed care and they were afraid that they would lose additional services if they voiced their concerns.

Billing, Claims and Contracted Rates

Providers are encountering payment issues with all three MCOs. A provider encountered issues where claims were denied for not being submitted before the timely filing deadline, but the delay in filing was a result of MCO issues like delays in processing contracts and having providers loaded into the system incorrectly. Providers had also encountered issues with payment delays where the MCOs were telling the providers that the IME had paid claims more quickly under FFS because they were paying some claims incorrectly and it takes longer to pay claims correctly. Organizations that could not carry expenses for services rendered for long periods of time while the MCOs identified payment issues were going to be forced to close and some already had closed.

Home- and Community-Based Services (HCBS) Waivers

Many new Case Managers (CMs) had little or no experience with Medicaid or available HCBS waiver services. Prior to implementation the Health and Disability (HD) Waiver program had targeted case management although this was no longer available and the new CMs were not aware of the change. A member's parent had power of attorney for her son, but the MCOs would not speak to her when she contacted their call centers and had been directed back to the CM who was not aware of the waiver policies. When the member's parent requested to speak with the CM's supervisor, they had been told that it was not possible. Regarding living arrangements for members on HCBS waivers, members on waiver services were previously able to live with a sibling who could serve as their host family and receive a daily payment although payments were now a limited hourly payment. Due to the reduction of host family payments, many waiver families were working off the clock due to the necessary level of care for the member. A parent of a member stated that the Consumer Choice Options (CCO) program was a great program but proved problematic under managed care. Members speculate problems regarding the CCO program may be because the MCOs do not support the program or that the MCOs do not understand the program.

Non-Emergency Medical Transportation (NEMT)

A member's parent stated that NEMT services for HCBS waiver members had improved under their child's MCO. A member advocate stated that families who needed rides to medical appointments must follow a different process under managed care which may or may not result in being offered a ride, which may or may not be related to the marital status of the child's mother. There was a need for additional educational materials to help members to understand NEMT policies, processes, and so forth as MCOs were doing a poor job of communicating this information. The IME policies for NEMT were also not being consistently applied among the MCOs and transportation brokers.

Questions:

1. How can services be improved for member's who speak languages other than English? How can the materials be updated to notify members who speak English as a second language to contact the MCO or IME for documents in their language?
2. What is the current definition of a clean claim from the MCOs?
3. What percentage of claims submitted are clean claims?
4. Why aren't claims being paid in a timely manner?
5. Are peer-to-peer consultations tracked? If so, is this data publicly available?
6. How are each of the MCOs applying peer-to-peer reviews? Do the MCO policies differ? Is there a difference among the MCOs when defining medical necessity? It appears to be different for each MCO.
7. Does each of the MCOs have a specialized group that assists with only waiver populations? Who are waiver members and member representatives supposed to contact for assistance?